**The following are a list of key performance indicators that can be used in the design of your integrated health program. It is not a complete list but can be used to help think-through the design your integration program.**

### Sample of Integration Clinical Measures

The majority of the clinical indicators listed below are endorsed by the National Quality Forum (NQF). Additional information about any measure included in the list can be found in the NQF measures database www.qualityforum.org/Measures_List.aspx or from the measure source.

| Physical & Behavioral Health Measures | Measure Source | NQF Endorsed |
|---|---|---|
| **Screening and Prevention** | | |
| **Breast cancer screening**: Percentage of women ages 40–69 who had a mammogram to screen for breast cancer | NCQA | X |
| **Colorectal cancer screening**: Percentage of members ages 50–75 who had appropriate screening for colorectal cancer | NCQA | X |
| **Cervical cancer screening:** Percentage of women ages 21–64 who received one or more Pap tests to screen for cervical cancer | NCQA | X |
| **Chlamydia screening** in women: Percentage of women ages 16–24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year | NCQA | X |
| Patients aged 6 months and older seen for a visit between October 1 and the end of February who received an **influenza immunization** OR patient reported previous receipt of an influenza immunization | PCPI | X |
| Patients who had an outpatient visit and whose **BMI** was documented during the measurement year or the year prior to the measurement year. | NCQA | |
| Patients with a calculated **BMI** in the past 6 months or during the current visit AND if the most recent BMI is outside parameters, a follow-up plan is documented | CMS | X |
| Counseling on physical activity and/or nutrition for those with documented elevated **BMI** | ICSI - modified | |
| Patients identified as **tobacco** users who received cessation intervention during the two-year measurement period. | PCPI | X |
| **Diabetes** | | |

| Physical & Behavioral Health Measures | Measure Source | NQF Endorsed |
|---|---|---|
| Patients with hemoglobin A1c (HbA1c) test during the measurement year. | NCQA | X |
| Patients with hemoglobin A1c (HbA1c) level less than 7.0% (controlled) | NCQA | X |
| Patients with hemoglobin A1c (HbA1c) level less than 8.0% (controlled) | NCQA | X |
| Patients with hemoglobin A1c (HbA1c) level greater than 9.0% (poorly controlled). | NCQA | X |
| Low-density lipoprotein cholesterol (LDL-C) test performed. | NCQA | X |
| Patients with diabetes whose low-density lipoprotein cholesterol (LDL-C) level is less than 100 mg/dL | NCQA | X |
| Patients with diabetes whose blood pressure reading is less than 130/80 mm Hg. | NCQA | X |
| Patients with diabetes whose blood pressure reading is less than 140/90 mm Hg. | NCQA | X |
| Patients with diabetes with a body mass index (BMI) greater than 25 who have lost 10 pounds at any time in the last 12 months | NHLBI | |
| Urine protein screening | NCQA | X |
| Optimal diabetes care (A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with cardiovascular disease daily aspirin use unless contraindicated. | MCM | X |
| Eye screening for diabetic retinal disease. | NCQA | X |
| **Hypertension** | | |
| Patients with a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than or equal to 140/90 mmHg) during the measurement year | NCQA | X |
| Percentage of hypertensive patients who receive education on the usage of non-pharmacological treatments | ICSI | |
| **Substance Use** | | |

| Physical & Behavioral Health Measures | Measure Source | NQF Endorsed |
|---|---|---|
| a. Initiation of AOD Treatment. Patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.<br><br>b. Engagement of AOD Treatment. Patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. | NCQA | X |
| **Schizophrenia** | | |
| Adherence to oral psychotics for individuals with schizophrenia | CMS | X |
| Continuity of antipsychotic medications for treatment of schizophrenia | | X |
| Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications | NCQA | X |
| Diabetes monitoring for people with diabetes and schizophrenia | NCQA | X |
| Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia | NCQA | X |
| Follow-up after hospitalization for schizophrenia (7- and 30-day) | NCQA | X |
| Emergency department utilization for mental health conditions for people with schizophrenia | NCQA | |
| **Depression** | | |
| Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented. | CMS | X |
| Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during the **four** month measurement period. | MCM | X |
| Percentage of patients diagnosed with unipolar depression who receive an initial assessment that considers the risk of suicide | PCPI | X |
| Patients diagnosed with major depression or bipolar disorder who receive an initial assessment that considers alcohol and chemical substance use | CQAIMH | X |
| Percentage of patients presenting with depression who were assessed, prior to the initiation of treatment, for the presence of prior or current symptoms and/or behaviors associated with mania or hypomania | CQAIMH | X |

| Physical & Behavioral Health Measures | Measure Source | NQF Endorsed |
|---|---|---|
| Antidepressant medication management (effective acute phase treatment): percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 84 days (12 weeks). | NCQA | X |
| Antidepressant medication management (effective continuation phase treatment): percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days | NCQA | X |
| Percentage of patients who have reached remission at 6 months (+/- 30 days) after initiating treatment, e.g., have any PHQ-9 score less than 5 after 6 months (+/- 30 days) | MCM | X |
| Percentage of patients who have reached remission at 12 months (+/- 30 days) after initiating treatment, e.g., have any PHQ-9 score less than 5 after 12 months (+/- 30 days) | MCM | X |
| **Bipolar Disorder** | | |
| Percentage of patients treated for bipolar disorder with evidence of level-of-function evaluation at the time of the initial assessment and again within 12 weeks of initiating treatment | CQAIMH | X |
| Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide. | CQAIMH | X |
| Percentage of patients treated for bipolar disorder who are assessed for diabetes within 16 weeks after initiating treatment with an atypical antipsychotic agent | CQAIMH | X |
| **Non-Condition Specific** | | |
| Follow-up after hospitalization for mental illness | NCQA | X |
| Rate of re-admissions to psychiatric hospitals within 30 or 180 days | NOMS | |

Abbreviations:
CQAIMH-Center for Quality Assessment and Improvement in Mental Health
CMS-Centers for Medicare and Medicaid Services
MCM-Minnesota Community Measurement
NCQA-National Committee for Quality Assurance
NOMS-National Outcomes Measurement Set
PCPI-Physician Consortium for Performance Improvement

**Sample of Integration Quality Indicators**

The following sample of quality indicators was gathered from the literature and web resources. These indicators can be used to monitor your program's progress on integration of primary and behavioral healthcare for quality improvement purposes.

| Indicator | Source(s) | |
|---|---|---|
| Written procedures exist regarding access to primary care or other medical services, sharing of information, coordination of care | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| Cross training for the most common chronic medical and behavioral illnesses prevalent in the population served | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| The program ensures the availability of the following during program hours: psychiatrist or psychologist, primary care provider, other professional legally authorized to prescribe as needed, care coordinator, other qualified behavioral health practitioners | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| When neither a psychiatrist or primary care physician is a member of the team, either is available during hours of operation (either in-person, by telephone, or electronically) | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| The program offers **education** that includes: health promotion (diet, exercise); wellness, resilience and recovery; the interaction between mental and physical health; prevention/intervention (smoking cessation, substance abuse, increased physical activity, obesity, chronic disease); self-management | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| Policies regarding initial consent for treatment identify how information will be internally shared, how information is shared by collaborating agencies, the ability of the person served to decline services, the procedures to follow if services are declined | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| The person-centered plan is an individualized, integrated plan that includes medical needs and behavioral health needs and is developed in collaboration with the person served and other stakeholders as appropriate and is developed or reviewed by all staff necessary to carry out the plan | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| Written procedures guide ongoing communication among interdisciplinary team members | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| Degree to which individual care plans are shared with all care providers as well as the member | National Health Policy Group: SASI™: Self-Assessment for Systems Integration Tool | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |

| Indicator | Source(s) | |
|---|---|---|
| % Consumer/Pts satisfied with case management | Assessing Care of Vulnerable Elders Quality Indicator Library | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| % Consumer/Pts who can identify person responsible for care coordination across settings. | National Health Policy Group: SASI™: Self-Assessment for Systems Integration Tool | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| % Consumer/Pts that report they are easily able to get in touch with their care coordinator/case manager | AXIS Healthcare Consumer Satisfaction Survey | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| % Consumer/Pts reporting that service coordinators help them get what they need | Health Services Research Institute | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| % Consumer/Pts reporting that their care managers are knowledgeable and competent. | Health Services Research Institute; Program for All-Inclusive Care for the Elderly Performance Measure | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| % Consumer/Pts who feel it is a problem to receive advice/assistance from more than one case manager or care coordinator. | Indiana Medicaid Select Performance Measure | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| % CMHC Pts w/ annual Physical Exam | Druss, et al. (2001). Integ Med care for Pts w/ SPMI: Randomized trial, *Archives of Gen Psych.* 861-68. | Boardman (2006). Health access & integ. for Adults w/ SPMI, *Families, Systems & Health,* 3-18. |
| % CMHC Pts w/ Direct Contact w/ PCP | Druss, et al. (2001). Integ Med care for Pts w/ SPMI: Randomized trial, *Archives of Gen Psych.* 861-68. | Boardman (2006). Health access & integ. for Adults w/ SPMI, *Families, Systems & Health,* 3-18. |
| Avg Number Consumers/Pts w/ primary care visits w/ PCP | Druss, et al. (2001). Integ Med care for Pts w/ SPMI: Randomized trial, *Archives of Gen Psych.* 861-68. | Boardman (2006). Health access & integ. for Adults w/ SPMI, *Families, Systems & Health,* 3-18. |
| % Receiving routine Primary Healthcare Screening & Associated Interventions | Druss, et al. (2001). Integ Med care for Pts w/ SPMI: Randomized trial, *Archives of Gen Psych.* 861-68. | Boardman (2006). Health access & integ. for Adults w/ SPMI, *Families, Systems & Health,* 3-18. |
| % people reporting service coordinators help them get what they need | Health Services Research Institute/Consumer Survey | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |

| Indicator | Source(s) | |
|---|---|---|
| Frequency of contacts with care coordinator/case manager | AXIS Healthcare Consumer Satisfaction Survey | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| Rate of care coordinator turnover | Wisconsin Family Care Performance Measure | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |

**Sample of General Program Quality Indicators**

These indicators of program/practice quality were gathered from literature and web resources. These indicators can be used for quality improvement purposes.

| Quality Indicator | Source(s) | |
|---|---|---|
| The program identifies hours when healthcare services are available | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| The following services are provided, as needed, to all persons served: care management, care coordination, transitional care, individual and family support services, interaction with family members, referral to needed community and social supports | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| Written screening procedures clearly identify when additional information will be sought in response to the presenting condition of the person served | CARF: Supplement to the Behavioral Health Standards Manual, Section 3-Behavioral Health Core Program Standards, Health Home www.carf.org/healthhome/ | |
| Length of time to schedule first appointment | Commission on Accreditation for Rehabilitation Facilities | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| Degree of consumer involvement in the planning, design, delivery, and evaluation of services | Commission on Accreditation for Rehabilitation Facilities | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| Degree to which consumers receive information to make informed choices | Commission on Accreditation for Rehabilitation Facilities | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| Degree to which consumers report that staff are sensitive to their cultural, ethnic, or linguistic background | Commission on Accreditation for Rehabilitation Facilities | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| Degree to which consumers believe they were respected by staff | Commission on Accreditation for Rehabilitation Facilities | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |

| Quality Indicator | Source(s) | |
|---|---|---|
| Degree to which people are informed about available resources in the community | Commission on Accreditation for Rehabilitation Facilities | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| Degree to which providers routinely communicate with family and informal caregivers. | National Health Policy Group: SASI™: Self-Assessment for Systems Integration Tool | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| Degree to which health plans/providers provide caregiver education, training and support | National Health Policy Group: SASI™: Self-Assessment for Systems Integration Tool | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| Degree to which linguistic accommodations are made | Commission on Accreditation for Rehabilitation Facilities | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |
| Proportion of families who report that services/supports are available when needed, even in a crisis. | Health Services Research Institute | CHCS Integrated Care Program: Performance Measures Recommendations (2006) |